

Managing STIs  
among MSM:

# Providing sensitive and competent care

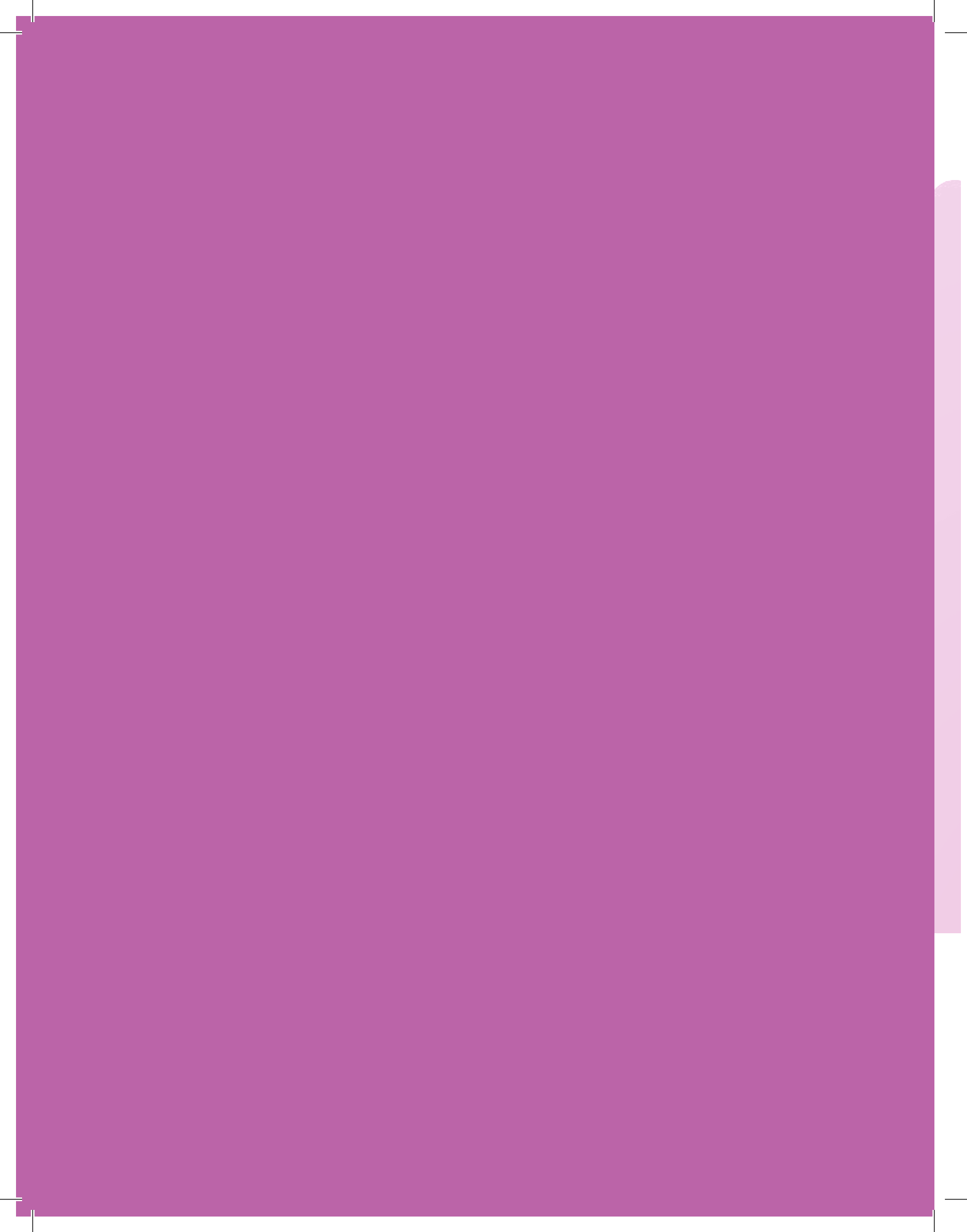
Facilitator Manual and  
Resource Material

December 2014



**National AIDS Control Organisation**

India's voice against AIDS  
Ministry of Health & Family Welfare, Government of India  
[www.naco.gov.in](http://www.naco.gov.in)



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सत्यमेव जयते



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सत्यमेव जयते

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Government of India

Ministry of Health & Family Welfare

National AIDS Control Organisation

## FOREWORD

The National AIDS Control Organisation (NACO) has been implementing exclusive Targeted Interventions (TI) for the high-risk group of Men having Sex with Men (MSM). There are 149 exclusive MSM TIs covering 2.38 lakh MSMs. The capacity building of the various functionaries of TIs is being carried out through the State Training Resource Centres (STRC), but has always been a challenge in absence of formal training modules for MSM TIs. To address this, NACO has come out with a set of training modules designed for different cadres involved in implementing NACP. These modules have been developed with rigorous consultation and deliberations with experts, and involvement of community members over a period of time.

The seven training modules for Doctors, Program Managers, Counselors, Out Reach Workers (ORW), and Peer Educators (PEs); and the training modules on Advocacy and Induction are developed for ensuring sensitive and quality service delivery to the target group.

I would like to acknowledge the effort that has gone into developing the modules. The contribution made by the Targeted Intervention (TI) and National Technical Support Unit (NTSU) Divisions of NACO for developing and coordinating with the various stakeholders to bring to fruition these training modules is also recognised. I am grateful to all the community leaders and members who have contributed to the development of the various chapters. I would also like to acknowledge the technical and financial support of UNDP in developing and printing these training modules. I would also like to acknowledge the State AIDS Control Societies (SACS), Technical Support Units (TSUs), State Resource and Training Centres (STRCs) for providing relevant input in the modules.

I hope that these training modules will help upgrade the skills of the frontline workers and thereby bring improvements in implementation in the TIs and in all spheres of MSM interventions.

(N.S. Kang)

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अपनी एचआईवी अवस्था जानें. निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ

# Abbreviations & Acronyms

AIDS	Acquired Immunodeficiency Syndrome
DAC	Department of AIDS Control
HIV	Human Immunodeficiency Virus
LGBT	Lesbian, Gay, Bi-sexual, Transgender
HCP	Health Care Providers
MoHFW	Ministry of Health and Family Welfare
MSM	Men who have Sex with Men
NACO	National AIDS Control Organization [India]
NGOs	Non Governmental Organizations
STIs	Sexually Transmitted Infections





## Key References

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## Schedule of The Training

Session	Duration	Schedule
Introduction	30 mins	9:30 am – 10:am
Sexuality related terms and concepts	45 mins	10:00 am – 10:45 am
Homophobia and Heterosexist	15 mins	10:45 am – 11:00 am
Tea/ Coffee Break	15 mins	11:00 am – 11:15 am
Frequently Asked Questions	45 mins	11:15 am – 12:15 pm
Card exercise to clarify common queries	30 mins	12:15 pm – 12:45 pm
Lunch	30 mins	12:45 pm – 1:15 pm
Sexual practices	30 mins	1:15 p m- 1:45 pm
Sexual history taking	1 hour	1:45 pm – 2:45 pm
STI- Basics	15 mins	2:45 pm – 3:00 pm
STI associated syndrome and management in MSM	1: 30 hour	3:00 pm – 4:30 pm
STI/HIV testing recommendation for MSM	15 mins	4:30 pm – 4:45 pm
Barriers to health care among MSM	45 mins	4:45 pm – 5:30 pm
Wrap Up	15 mins	5:30 pm – 5:45 pm



# Purpose of this Manual

Men who have sex with Men (MSM) in India have relatively high STI and HIV prevalence (national average - 4.5%) when compared to the general population (0.3%). In spite of a decade of HIV interventions programmes among MSM, most health care providers have limited understanding about who are MSM, what their health care needs are and what can be done by doctors to improve the sexual health of MSM.

Lack of medical curriculum on the issues of sex and sexuality, especially same-sex relationships and issues of Lesbian, Gay, Bi-sexual and Transgender (LGBT) means most health care providers often did not have correct knowledge about these issues, most importantly issues of MSM, nor do they know how to interact sensitively with their MSM patients or how to take sexual history and treat them in a sensitive and empathetic manner. While incorporating information about sexual minorities in the medical curriculum is a key long-term solution, for those doctors who are currently practicing, offering training to competently address the health issues of sexual minorities can be another solution.

The main **goal** of this manual is to enable health care providers to provide quality sexual health care services (especially diagnosis and treatment of STIs) to MSM.

The **specific objectives** include:

1. To understand basic information about human sexual diversities (especially non-heterosexual sexualities)
2. To make the participants aware of their own attitudes and values with respect to sexual diversity, and to enable them to be respectful and caring towards their patients who are MSM
3. To improve the knowledge and skills of doctors in taking sexual history from MSM for STI diagnosis, treatment and counseling.
4. To improve the knowledge and skills of doctors in providing risk-reduction counseling to MSM.
5. To understand the barriers faced by MSM in accessing clinical services, and what can be done by the doctors

## Expected Outcomes

Training of doctors using this manual (or self-reading of the manual, slides and handouts) can result in increased knowledge, and enhanced skills of the doctors on the sexual health issues of MSM that will ultimately lead to improvement in the quality of STI/HIV services for MSM.



# 1. Introduction

## a. Introduction of the facilitators

Facilitators need to introduce themselves briefly to the participants. The introduction will include credentials and institutional affiliations and their expertise in facilitating this training course. A single facilitator can handle the entire training but it may be useful to have at least one co-facilitator.

## b. Introduction of the participants

Ask the participants to briefly introduce themselves: their name, the institution to which they belong, their role and expectations from the training program (if time permits). The expectations are to be written on a poster for review at the end of training.

## c. Pre-training evaluation

Explain why pre- and post-training evaluations are necessary:

- Mainly to assess the knowledge (and attitude) of the participants before and after the training and to find out whether there is any difference after the training.

Explain that the participants need not write their names on the questionnaires (pre-/post training evaluation). But ask them to write the particular number assigned to them in the training. Each participant has to write the same number assigned to them in both the pre and post-training questionnaire. Note the questionnaire is the same and hence the participants have to indicate by ticking whether the evaluation is pre- or post-training.

A model pre-/post-training evaluation questionnaire is given in the appendix. Facilitators can modify this questionnaire as per their training schedule and requirements of the participants.

## d. Goals and objectives of the training

Explain the goals and objectives of the training to the participants.

### Goal

To enable health care providers to provide quality sexual health care services (especially diagnosis and treatment of STIs) to MSM.

### Objectives

1. To understand basic information about human sexual diversities (especially non-heterosexual sexualities)
2. To make the participants aware of their own attitudes and values with respect to sexual diversity, and to enable them to be respectful and caring towards their patients who are MSM
3. To improve the knowledge and skills of doctors in taking sexual history with MSM during STI diagnosis, treatment and counseling.
4. To improve the knowledge and skills of doctors in providing risk-reduction counseling to MSM.
5. To understand the barriers faced by MSM in accessing clinical services, and what can be done by the doctors

Brief the participants on the duration of the training period. A model one-day training

schedule is given as appendix-1. Request the participants to read the participant resource handbook and any additional handouts given to them once the training is over. Depending upon the training needs and time duration available, the duration of various sessions can be modified by the facilitator.

### e. Ground Rules

(Adapted from Trainer's manual of LGBT Health Access Training Project)

The following ground-rules need to be read out from the Power Point™ slides. If possible, charts in which these ground rules are written can be posted in the walls of the training room.

#### Resource for facilitators: Setting Ground Rules

##### Respect others' opinions

- Agree to disagree.
- We come from a variety of backgrounds and experiences.

- What is one person's truth may not be the truth of another.
- We come together to share and to learn, not to judge.
- Use respectful language.
- All feelings are valid.

##### Speak from personal experiences

- When speaking use "I" statements when appropriate. (Example: "I feel it is wrong to have sex before marriage" rather than "It is wrong to have sex before marriage")

##### Questions

- There are no "foolish" questions.
- Challenge yourself to ask questions as they arise

##### Participation

- People are encouraged to speak freely
- Speak one at a time
- We want to encourage you to be non-judgmental and open to different perspectives.



## 2. Sexuality-Related Terms & Concepts

<b>Objective</b>	To help the participants understand the meaning of the key terms used in the area of sexuality.
<b>Methods</b>	Slide presentation or overhead projector presentation.
<b>Supplies or Equipment</b>	<ul style="list-style-type: none"><li>• LCD projector or overhead projector</li><li>• Copies of the handout 'Glossary of Terms'</li></ul>
<b>Time needed</b>	45 min

### Instructions for the facilitator

- Find out appropriate terms in the native languages of the participants. Often, there may not be appropriate equivalent terms in the native language. For example, there is no term in most (if not all) of the Indian languages for 'heterosexual' or 'bi-sexual'. (Note: There may be recently coined technical terms for 'homosexual' or 'homosexuality' in the native languages.)
- Go from simple terms to complex
- Not all the key terms in the field of sexuality need to be taught – only those terms that are relevant for the discussion in this course need to be given importance.
- Interaction with the participants in this session is very crucial since they need to be very clear in the basic and key terminology that will be used throughout this training.

### Steps

Brief the audience on the importance of understanding the basic terminology and concepts in sexuality for better understanding and appreciation.

The definitions of the following can be then shown and explained:

- Sex
- Sexuality
- Gender
- Sexual orientation (homosexual, heterosexual, bi-sexual)
- Sexual behavior (homosexual, heterosexual, bi-sexual)
- Sexual identity (gay, bi-sexual, lesbian)
- Gender expression
- Gender identity
- Transsexualism
- Transsexual (male-to-female transsexual, female-to-male transsexual)
- Transgender

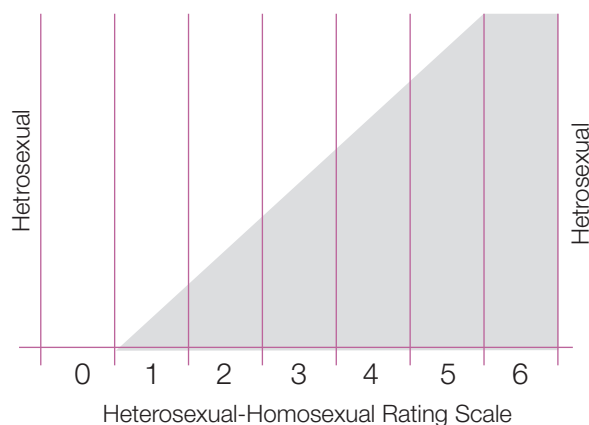
**Note:** Although this manual is about MSM, it is important for the clinicians to understand the difference between MSM and transgender/transsexual people. Hence, the trainers need to provide 'definitions' of these terms, and explain the differences and similarities between MSM and transgender/transsexual people.

Give examples and exercises to the participants to understand the difference between the following:

- Sex and gender
- Sex and sexuality
- Sexual orientation and sexual behavior
- Sexual identity and gender identity

Give examples and provide explanations to show that:

- Feminine gender expression may or may not be associated with homosexual orientation (a male can be feminine and still have heterosexual orientation/behavior, a male can be masculine but still have a homosexual orientation/behavior).
- Sexual identity and sexual behavior may or may not correlate (a gay-identified male may get married to a woman and have bi-sexual behavior, a person without a gay identity might have had same-sex behavior).
- Point out that masculine and feminine are not dichotomous notions, but rather a continuum and very much based in the culture and era in which one lives. A modified Kinsey's sexual attraction/behavior scale is given below<sup>1</sup>.



Copyright © The Kinsey Institute. <http://www.kinseyinstitute.org/research/ak-hhscale.html>

- 0 Exclusively heterosexual with no homosexual [attraction/behavior].
- 1 Predominantly heterosexual, only incidentally homosexual.
- 2 Predominantly heterosexual, but more than incidentally homosexual.
- 3 Equally heterosexual and homosexual.
- 4 Predominantly homosexual, but more than incidentally heterosexual.
- 5 Predominantly homosexual, only incidentally heterosexual.
- 6 Exclusively homosexual.

Once the participants understand the above, tell the participants that gender expression and sexual orientation can be viewed as continuum rather than polar categories of masculine and feminine or heterosexual and homosexual, respectively.

After explaining the above definitions, define and explain the following terms:

- Men who have sex with men (MSM)
- Kothi
- Panthi
- Double-Decker
- Gay
- Bi-sexual

**Note:** Definitions for these terms are provided below.

### Important: Identities Vs. Behavior

While it is the behavior that puts people at risk for HIV, one should not overlook the importance of identities like Kothi, gay or bi-sexual among MSM populations. Identities are important in

<sup>1</sup>As there is a criticism that Kinsey's scale measures only two dimensions (attraction and behaviour), one can also consider using Klein's multi-dimensional sexual orientation grid (<http://www.americaninstituteofbi-sexuality.org/thekleingrid/>)



relation to community mobilization, and the psychosocial support provided by the presence of communities. Hence prevention and care programs should also be culturally appropriate and respect the identities chosen by MSM.

## Definitions of Sexuality-related Terms

(From diverse sources: [www.indianLGBThealth.info](http://www.indianLGBThealth.info); WPATH SOC 7th edition – [www.wpath.org](http://www.wpath.org); IPPF online glossary: [www.ippf.org/resources/media-press/glossary](http://www.ippf.org/resources/media-press/glossary))

### Sex and sexuality

**Sex** refers to biological status as male or female. It includes physical attributes such as sex chromosomes, gonads, sex hormones, internal reproductive structures, and external genitalia.

**Gender** is a term that is often used to refer to ways that people act, interact, or feel about themselves, which are associated with boys/men and girls/women. While aspects of biological sex are the same across different cultures, aspects of gender may not be.

**Sexual orientation** refers to attractions, behaviours, fantasies, and emotional attachments toward men, women, or both. Transgender people may be sexually attracted to man, woman or both.

### Identity

How one thinks of oneself, as opposed to what others observe or think about one. However, there is a close symbiosis in societies between the formation of a sense of self-identity and the social and cultural application of labels to describe people. Identities are not acquired in

isolation and are profoundly social in character.

**Gender identity** refers to a person's internal, deeply felt sense of being either man or woman, or something other or in between. Because gender identity is internal and personally defined, it is not visible to others.

**Sexual identity** refers to an inner sense of oneself as a sexual being, including how one identifies in terms of gender identity and sexual orientation. That is, whether one identifies as a heterosexual, homosexual or bi-sexual person.

A person's '**gender expression**', in contrast to gender identity, is external and socially perceived. Gender expression refers to all of the external characteristics and behaviours that are socially defined as either masculine or feminine, such as dress, mannerisms, speech patterns and social interactions.

**Gender non-conformity** refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011).

### MSM-related terms

#### **Men who have Sex with Men (MSM)**

This term is used to denote all men who have sex with other men, regardless of their sexual identity or sexual orientation. This is because a man may have sex with other men but can still consider himself to be a heterosexual or may not have any particular sexual identity at all.



### ***Kothi<sup>2</sup>***

'Kothis' are a heterogeneous sub-group of same-sex attracted males. They can be described as biological males who show varying degrees of 'femininity', which may be situational (only expressed in specific contexts). Some proportion of kothis have sex with or are married to women. Kothis are generally from lower socio-economic status and some engage in sex work for survival. Some proportion of Hijra-identified people may also identify themselves as 'kothi', but not all kothi-identified people identify themselves as Hijra or transgender.

### ***Double Decker***

Kothis and hijras label those men who insert and receive during penetrative sexual encounters (anal or oral sex) with other men as 'Double' or 'Double Decker' or even 'DD'. These days, some proportion of such persons also self-identify as 'Double' or 'DD'. Other terms that are used in some states include 'Dupli' or 'Dho Paratha'.

### ***Panthi***

The term 'Panthi' is used by kothis and thirunangai/hijras to refer to their masculine insertive male partner or anyone who is masculine and seems to be a potential sexual (insertive) partner.

### ***Gay man (here 'gay' as a self-identity)***

A gay man may be understood as someone who has significant (to oneself) sexual or romantic attractions primarily to members of the same gender or sex, or who identifies as a member

of the gay community. One may identify as gay without identifying as a member of the gay community and vice versa. Though 'gay' is a common term for male and female same-sex attracted persons, it is more often used to denote same-sex oriented men. Self-identified gay men do not necessarily have sex only with men, but occasionally may engage in sex with women, especially in countries such as India where adult men face considerable social pressures to marry and/or practice heterosexuality.

### ***Bi-sexual man (here 'bi-sexual' as a self-identity)***

A bi-sexual man may be understood as someone who has significant (to oneself) sexual or romantic attractions to members of the same gender and/or sex and another gender and/or sex people who are attracted to members of both genders or sexes may be monogamous, polyfidelitous or non-monogamous.

### **Transgender-related terms**

***Transgender person*** is an individual who does not identify with the gender assigned to them at birth and their experienced gender (self-assigned or self-identified gender) may be opposite to that of the birth assigned gender. Transgender person may also identify as a gender that is in between man and woman or neither man or woman.

***Male-to-female (MtF) transgender person*** is an individual who is born as a natal male (male sex by birth) but whose gender identity is woman (or in between man and woman). Also known as transgender woman or ***trans woman***.

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<sup>2</sup> Chakrapani, V., Kavi, A. R., Ramakrishnan, R. L., Gupta, R., Rappoport, C., & Raghavan, S. S (2002). HIV prevention among men who have sex with men (MSM) in India: Review of current scenario and recommendations. SAATHII, India. Available at [www.indianLGBThealth.info](http://www.indianLGBThealth.info)  
This definition is based on the consensus definition in a national consultation organised by UNDP India on hijras/transgender people (held in New Delhi in 2010).



**Female-to-male (FtM) transgender person** is an individual who is born as a natal female (female sex by birth) but whose gender identity is man (or in between man and woman). Also known as transgender man or **trans man**.

**Transsexual** is an adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

**Sex reassignment surgery** refers to surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an

important part of medically necessary treatment to alleviate gender dysphoria.

**Intersex or Intersexuality** refers to congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some medical professionals prefer the term 'disorders of sexual development' instead of 'intersex'.

### **Hijras<sup>3</sup>**

Individuals who voluntarily seek initiation into the Hijra community, whose traditional profession is badhai but due to the prevailing socioeconomic and cultural conditions, a significant proportion of them are into begging and sex work for survival. These individuals live in accordance to the community norms, customs and rituals which may vary from region to region.



## 3. Homophobia and Heterosexism

<b>Objective</b>	To make the participants understand the meaning of homophobia and heterosexism
<b>Methods</b>	Slide presentation or overhead projector presentation.
<b>Supplies or Equipment</b>	LCD projector or overhead projector
<b>Time needed</b>	10 to 15 min

### Steps

Give definitions and explanations for the following terms.

- Homophobia
- Heterosexism

### Definitions

**Homophobia (n.):** [Gr. homo (man) + phobia (fear).] 1. An irrational hatred and fear of lesbian, gay and bi-sexual people that is produced by institutionalized biases in a society or culture. 2. A term for all aspects of the oppression of lesbian, gay and bi-sexual people.

**Heterosexism (n):** The oppression of lesbian, gay and bi-sexual people. The assumptions that identifying as heterosexual and having sexual and romantic attractions only to members of another gender or sex is good and desirable, that other sexual identities and attractions are bad and unacceptable, and that anyone whose sexual identity is not known is heterosexual. Usually

coupled with both unconscious and willful “blindness” to the existence and concerns of lesbian, gay and bi-sexual people. A heterosexist is one who practices (believes in) heterosexism.

Explain how homophobia combined with heterosexism constitute barriers in providing quality health care to MSM.

(Interaction with the participants in this session is important.)

### Optional

- Ask the participants to give examples of homophobia they have seen or heard from their clients in their practice.
- You can ask the participants to think of some time in their life when they felt discriminated against or when someone exhibited a prejudice against them. This might help them to “understand the prejudices experienced by MSM and the toll it takes on their lives and emotional well-being”. Note that for some people this might be a stressful activity.

<sup>3</sup> This definition is based on the consensus definition in a national consultation organised by UNDP India on hijras/transgender people (held in New Delhi in 2010).



## 4. Q & A Session or Frequently Asked Questions (FAQs)

<b>Objective</b>	The participants should get clarifications on the common queries they might have about men who have sex with men (MSM).
<b>Methods</b>	The participants are encouraged to ask whatever queries they have about MSM. If the participants don't have any queries, then ask the questions listed here and encourage them to provide answers to them.
<b>Supplies or Equipment</b>	<ul style="list-style-type: none"><li>• White-board and marker pens to note down the queries from the participants</li><li>• List of questions to the participants (in case participants do not come out with questions)</li></ul>
<b>Time needed</b>	30 to 45 min

### Steps

It is better to have a separate session to clarify the queries the participants might have but which are not covered in the previous sessions. Some of the common queries asked by the participants in any of the sessions of the training are given below. If the participants ask any of these queries in previous sessions tell them that they will be given answers/explanations in Q & A session. Although many of the queries in this session are actually 'myths and misconceptions', it is better to use the neutral term 'Q & A session'.

Some of the common queries are listed below and brief explanations are given as a handout.

If the participants have understood the terms and concepts well having this session may be

redundant. However, some participants may have certain misconceptions so much ingrained that they cannot able to get rid of them easily and for them this is an opportunity to raise their queries.

Some of the queries like whether homosexuality is a mental disorder might not have been addressed in the previous sessions and this session offers the chance to explain those areas better.

List of some common queries:

- Is same-sex attraction (homosexuality) a mental illness?
- Can homosexuality be "cured" by appropriate therapy?
- Can homosexual people be identified by their mannerisms or appearance?

**Note:**

- Additional questions that might be asked is listed in a handout from the American Psychological Association (APA) and available as a pdf document at: <http://www.apa.org/topics/lgbt/orientation.pdf>
- The trainer is strongly recommended to read this handout to answer similar questions from the participants. Handout can be distributed to the participants or they can be asked to download and read this handout.

## Explanations

### Is same-sex attraction (homosexuality) a mental illness?

*Adapted from American Psychological Association (APA):*  
<http://www.apa.org/topics/lgbt/orientation.aspx>

No, lesbian, gay, and bi-sexual orientations are not disorders. Research has found no inherent association between any of these sexual orientations and psychopathology. Both heterosexual behavior and homosexual behavior are normal aspects of human sexuality. Both have been documented in many different cultures and historical eras. Despite the persistence of stereotypes that portray lesbian, gay, and bi-sexual people as disturbed, several decades of research and clinical experience have led all mainstream medical and mental health organizations in many parts of the world as well as the World Health Organization (WHO) to conclude that these orientations represent normal forms of human experience. Lesbian, gay, and bi-sexual relationships are normal forms of human bonding.

### Can homosexuality be “cured” by appropriate therapy?

From American Psychological Association (APA):  
<http://www.apa.org/topics/lgbt/orientation.aspx>

All major national mental health organizations have officially expressed concerns about therapies promoted to modify sexual orientation. To date, there has been no scientifically adequate research to show that therapy aimed at changing sexual orientation (sometimes called reparative or conversion therapy) is safe or effective. Furthermore, it seems likely that the promotion of change therapies reinforces stereotypes and contributes to a negative climate for lesbian, gay, and bi-sexual persons. This appears to be especially likely for lesbian, gay, and bi-sexual individuals who grow up in more conservative religious settings.

Helpful responses of a therapist treating an individual who is troubled about her or his same-sex attractions include helping that person actively cope with social prejudices against homosexuality, successfully resolve issues associated with and resulting from internal conflicts, and actively lead a happy and satisfying life. Mental health professional organizations call on their members to respect a person's (client's) right to self-determination; be sensitive to the client's race, culture, ethnicity, age, gender, gender identity, sexual orientation, religion, socioeconomic status, language, and disability status when working with that client; and eliminate biases based on these factors.

*Note: As mentioned earlier, facilitators and participants can also refer to the APA handout:*  
<http://www.apa.org/topics/lgbt/orientation.pdf>



## 5. 'Card Exercise' to Clarify Common Queries

**Note:** This exercise can be used if Q&A session (previous session) on common queries is not conducted.

<b>Objective</b>	To make the participants examine false and true statements about MSM and hence to remove any misconceptions.
<b>Supplies or Equipment</b>	<ul style="list-style-type: none"><li>• Cards which contain correct and false statements about MSM</li><li>• Handout containing explanations for the common queries</li></ul>
<b>Time needed</b>	30 min

### Steps

The facilitator has many cards each containing one statement (true or false) about MSM. He/she reads out what is written in each card and asks what the participants think about that statement. The participants are encouraged to tell their opinion. Interactions among the participants are encouraged rather than the facilitator trying to answer or respond to the comments from each participant. After a reasonable period of discussion on a particular statement, the facilitator intervenes and summarizes the discussions and gives the rationale behind why a particular statement is a myth or fact.

Below is a list of statements (false or true) that can be used for this exercise.

- Homosexuality is abnormal

- Homosexuality is unnatural
- Homosexuality is not a mental illness
- Homosexuality can be cured by appropriate therapy
- Homosexual people can be identified by their mannerisms, or appearance.
- Gay people could be cured if they have sex with a person of the opposite sex.

### Note:

- The trainer is strongly recommended to read the handout from the American Psychological Association (APA) and available as a pdf document at: <http://www.apa.org/topics/lgbt/orientation.pdf>
- Handout can be distributed to the participants or they can asked to download and read this handout.

### Instructions for the facilitators

Note that some participants may not be satisfied with your 'rationale' behind why a particular statement is a myth or fact. Acknowledge that it may not be possible for everyone to agree or disagree with certain statements and at least make them understand it might have definitely challenged the way they might have thought about that initially. And then move forward to other statements or next session.

### Variants of this exercise

Each of the participants can be given one card containing a statement (false or true) and asked to comment on that statement. Later the other participants are asked to talk about their views on that statement. Finally the facilitator intervenes and gives the rationale behind why a particular statement is false or true.



## 6. Sexual Practices

<b>Objective</b>	To make the participants understand the various sexual practices – penetrative and non- penetrative, so that the clinicians can understand the sexual practices of MSM, as well as develop skills in eliciting information related to their sexual practices during sexual/STI history taking. The participants also need to understand the relative risk of acquiring or transmitting HIV infection through the various (unprotected) sexual practices.
<b>Methods</b>	<ul style="list-style-type: none"><li>• Discussion</li><li>• Slide presentation or overhead projector presentation.</li></ul>
<b>Supplies or Equipment</b>	LCD projector/overhead projector
<b>Time needed</b>	30 min

### Steps

1. Introduce the terminology for the various types of penetrative or non-penetrative sexual practices.
2. Ask them to find out or create appropriate terms in their native languages so that they can ask about these sexual practices with their clients.
3. For the following sexual practices, mention the relative risk of acquiring or transmitting HIV:
  - unprotected anal sex
  - unprotected vaginal sex
  - unprotected peno-oral sex.

### Note:

- The participants should be able to understand that any type of sexual practices, if not limited by the absence of a particular anatomical part, can occur between any one (man and man, man and woman, , woman and woman) except probably the peno-vaginal sex which happens between a man and a woman.
- The participants should also be able to understand that persons of any sexual orientation can practice any of the sexual practices. For example, anal sex may be practiced between a man and a woman. A gay-identified man may engage in vaginal sex with a woman (Participants can be directed to read about Klein's sexual orientation grid:

<http://www.americaninstituteofbisexuality.org/thekleingrid/>.

## Key points to convey

Unprotected anal sex (whether between two men or between a man and a woman) has highest risk of HIV infection. This is followed by unprotected peno-vaginal sex (medium risk of HIV infection) and unprotected peno-oral sex (low risk of HIV infection).

## Resource material

For simplicity, we can classify sexual practices as penetrative and non-penetrative.

## Penetrative sexual practices

Penetrative sexual practices usually involve contact with semen or vaginal fluid and may lead to minor abrasions in vaginal or anal mucosal membrane, all of which pose a risk of acquiring or transmitting HIV (or STI).

### Peno-vaginal Intercourse (Vaginal sex)

Insertion of the erect penis into the vagina, followed by rhythmic movement often leading to orgasm.

### Anal intercourse (Anal) sex

Insertion of the penis into the rectum/anus. This sexual practice can happen between two men or between a man and a woman. The man who inserts the penis is called 'insertive partner' and the person (man or woman) who receives is called "receptive partner". In sex between men,

insertive and receptive roles can change with the same partners or with different partners.

### Fellatio (Peno-oral sex, oral sex on a man or simply as "oral sex")

Stimulation of the penis using the lips, mouth, or tongue. This can be practiced between two males or between a man and a woman. Practice may or may not be continued to orgasm, and the partner may or may not swallow the ejaculate.

### Cunnilingus (Oro-vaginal sex or "oral sex on a woman" or simply "oral sex")

Stimulation of the external genitals of the woman with lips, mouth, or tongue by a man or woman. This practice may or may not be continued to orgasm.

### Anilingus (Oro-anal sex or "rimming")

Oral stimulation of the anal area.

(Insertion of fingers into the rectum or vagina is called "**fingering**" and Insertion of hands is termed "**fisting**.")

## Non-penetrative Sexual /Erotic practices

### Cybersex

Sex-related activities involving the Internet. Includes sexual fantasy between individuals or groups through games, chat rooms, bulletin boards, instant messaging services, and other sources.





### Phone-sex

Using fantasy and erotic talk on the phone with a partner.

### Body rubbing (“Body sex”)

Rubbing bodies together, especially sexual organs (“Frottage”), sometimes leading to orgasm.

### Interfemoral intercourse (“Thigh sex”)

Inserting and moving the penis between the thighs.

### Erotic fantasy

Reading, watching, imagining, telling, or acting out erotic fantasies with or without a partner.

### Erotic massage

Sensual and sexually arousing body massage, which sometimes includes stimulation of the sexual organs with hands, body, or mouth.

### Foreplay

Sexual activity including caressing, touching, stroking, kissing (dry or French), massaging, breast sucking, and other types of bodily contact that promotes sexual excitement (erection or vaginal lubrication). This type of sexual activity may or may not lead to orgasm and does not necessarily lead to sexual intercourse.

### Masturbation (Self/Mutual/Group)

Manual or other nonpenetrative stimulation of oneself (self-masturbation) or a partner for sexual pleasure (Mutual masturbation). Under some definitions, it may also include penetrative stimulation of oneself.

### Group sex (Orgy)

Simultaneous sexual activity among more than two people.

### Sex toys

Objects used for or designed for enhancing sexual pleasure (including dildos, vibrators, and implements used for bondage).

### ***Relative risk of HIV transmission/ acquisition in unprotected anal, vaginal and oral sex***

- Unprotected anal sex whether between two men or between a man and a woman carries the highest risk of transmission or acquisition of HIV if one of the partners is HIV-infected. In anal sex, the efficiency of transmission of HIV from an insertive to receptive partner is more than that from receptive to insertive partner.
- Unprotected vaginal sex, when compared to unprotected anal sex, carries a moderate risk of HIV transmission or acquisition when one of the partners is HIV-infected.



- Unprotected peno-oral sex (“oral sex”) carries a relatively lower risk compared to unprotected anal or vaginal sex.

**From CDC: Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act\*** (<http://www.cdc.gov/hiv/policies/law/risk.html>)

\* Factors that may increase the risk of HIV transmission include sexually transmitted diseases, acute and late-stage HIV infection, and high viral load. Factors that may decrease the risk include condom use, male circumcision, antiretroviral treatment, and pre-exposure prophylaxis. None of these factors are accounted for in the estimates presented in the table.

Type of Exposure	Risk per 10,000 Exposures
Parenteral <sup>3</sup>	
Blood Transfusion	9,250
Needle-sharing during injection drug use	63
Percutaneous (needle-stick)	23
Sexual <sup>3</sup>	
Receptive anal intercourse	138
Insertive anal intercourse	11
Receptive penile-vaginal intercourse	8
Insertive penile-vaginal intercourse	4
Receptive oral intercourse	low
Insertive oral intercourse	low



## 7. Sexual History Taking

<b>Objective</b>	To improve the skills of doctors/counselors in asking about same-sex/bi-sexual behavior among their clients (men)
<b>Methods</b>	Slide presentation or overhead projector presentation. Role-play.
<b>Supplies or Equipment</b>	<ul style="list-style-type: none"><li>• LCD projector/overhead projector</li><li>• Role-play scenarios</li></ul>
<b>Time needed</b>	45 - 60 min

### Steps

1. Start with a question: Why most doctors have difficulty in taking sexual history in detail even in those patients who come specifically with sexual problems or for STD/HIV testing or 'check-up'. You can ask the participants to give various reasons. Then cover the relevant slides. (A handout is available)
2. Proceed to how, in general, sexual history need to be taken. These basic points can be covered with specific examples for each point.
3. Then, talk about the possible ways of asking about the same-sex or bi-sexual behavior in any male (whether that person is masculine or feminine, young or old, single or heterosexually married). Some possible 'scripts' are given in the slides but ask them to develop their own scripts that need to be tailored according to individual client characteristics.

### Resource material for the session 'Sexual History Taking' with MSM

Based on the section: Addressing Same-Sex/Bi-sexual Behavior in HIV/STI Risk Assessment. In Chakrapani. V. (2005). "Understanding Men Who Have Sex With Men (MSM) and Hijras & Providing HIV/STI Risk-Reduction Information Handbook for Clinicians & Counselors in Sexual health/STI/HIV".

During STI/HIV risk assessment or in a regular sexual health screening, a significant proportion of doctors and counselors may not take sexual history in detail for a variety of reasons which could be due to:

- Embarrassment
- Feeling that they are not adequately trained in asking sex-related questions
- Fear of the emotions generated by such a discussion
- Awkwardness with sexual language

However, when doctors and counselors do not ask about same-sex/bi-sexual behavior in their

male clients, they are losing crucial opportunities to provide HIV/STI prevention education to these persons from marginalized populations. Thus, irrespective of whether a person has sex with males, females or both, a detailed sexual history is important for all patients because it provides information that

- Identifies those at risk for sexually transmitted diseases, including HIV;
- Directs risk-reduction counseling; and
- Identifies what anatomic sites are suitable for STD screening.

### Subpopulations of men who have sex with men (MSM) in India

‘MSM’ is a behavioral term and denotes all men who have sex with other men regardless of their sexual identity.

For the sake of simplicity, one can classify ‘MSM’ according to their socioeconomic and educational status as follows:

*MSM from lower socioeconomic class with poor literacy:* Kothi-identified homosexual males are a visible and relatively organized group. One can say that Kothi means feminine homosexual males who are mainly receptive partners. **Kothis** call their masculine partners as ‘**Panthi**’. Panthis are supposed to be “real men who only penetrate”. The term ‘**Double-decker**’ is used by Kothis to refer to someone who penetrates as well as receive.

*MSM from the ‘middle or upper class’:* MSM belonging to ‘middle or upper class’ who are

well-educated may have identities like **gay** or **bi-sexual**.

However, the major subpopulation across any socioeconomic class is likely to be MSM who do not have any conscious homosexual identity.

### Asking about same-sex/bi-sexual behavior in males

1. *Ask about same-sex behavior/bi-sexual behavior in all male clients*

Counselor should not limit asking their clients about same-sex behavior only if they appear ‘feminine’. Men who have sex with men can be masculine or feminine and hence one should not consider gender expression (behaving/appearing in a masculine or feminine manner) to be indicative of behavior.

2. *Ask about same-sex behavior even in married men*

There should be no assumptions that heterosexually married men cannot be having sex with men. MSM may or may not be heterosexually married. Thus even in married men, one has to ask about same-sex behavior.

3. *Ask about same-sex behavior across all age groups*

Don’t assume that only male youth will be involved in same-sex behavior, MSM belong to all age groups just like heterosexual men.



4. *Ask about heterosexual behavior in self-identified homosexual men*

Even if a male client openly comes out as that he is having sex with men and/or self-identifies as a homosexual man ('Kothi' or 'gay'), the counselor or doctor needs to ask whether he also has female partners. This is because even self-identified homosexual men often have female partners and eventually may get married heterosexually to fulfill family and societal expectations. Knowing about steady female partners of these men are thus important for referral services and discussing about partner treatment/testing if the client has STI or HIV.

5. *Ask about male steady partners of self-identified homosexual men*

Among those who admit having had same-sex behavior ask whether they have long term steady partners (Kothi-identified MSM may call these steady partners as 'Panthis'). Again, this has relevance in relation to partner notification and management

**Eliciting history of same-sex/bi-sexual behavior in a male: Some scripts**

There are a variety of ways to make the male client feel comfortable about talking about his same-sex/bi-sexual behavior. For this, developing an appropriate level of trust and rapport during the initial interactions is of importance.

*One example:*

Doctor: When did you last have sex?

Male Client: About a week ago

Doctor: With whom?

Client: ...With a lady in my neighborhood.

Here the interviewer starts with asking when he had sex and with whom. There were no assumptions about the gender of the sexual partners. Even if the male client tells he has had sex with a female it is important to tactfully ask about same-sex behavior in a nonjudgmental manner.

Doctor: You said you have had sex with many women. Have you ever had sex with men?

Male Client: (Pauses)....It was about six months ago.

Thus, here the interviewer did not assume that the male client was having sex only with females but asked whether he had sex with any men. If the client feels that the counselor is asking the question in a nonjudgmental manner he is more likely to be honest about whether he has sex with other men.

Now having asked about same-sex/bi-sexual behavior in your male clients, the next step is to ask about what kind of sexual practices they practice.

**Asking about various sexual practices**

It is important to know the types of sexual practices and condom use associated with them so that one can assess the risk of STI and HIV associated with various sexual practices and also to provide appropriate HIV risk-reduction counseling.

## Role play scenarios

The following scenarios can be acted upon by the participants. One should act as a doctor and the other as a patient. Note that these role-plays are to train or improve their skills in asking same-sex/bi-sexual behavior in any male.

- a. A 25-year-old unmarried masculine-looking male comes for HIV testing and the doctor needs to conduct HIV/STI risk assessment in this person. How the doctor will proceed to ask sexual behavior of this patient?
- b. A 30-year-old married male comes with STI symptoms. How you will ask sexual history in this patient? Note: This role-play should focus more on taking sexual history and not STI history.
- c. A 23-year-old male comes for HIV/STI testing and informs that he has had sex with males in the past. How do you take a comprehensive sexual history?

## Key points to convey

- Same-sex or bi-sexual behavior can be present in males who are masculine or feminine, young or old, single or married.
- A self-proclaimed homosexual male can also have sex with females.
- Not all the men who have homosexual orientation have anal sex.
- Sex between a man and woman may also involve oral or anal sex.
- A heterosexually married male may also be having sex with males (bi-sexual behavior).
- A person with gay or kothi identity can be heterosexually married.
- If a male acknowledges same-sex or bi-sexual behavior enquire about both male and female steady partners to facilitate partner screening and treatment.



## 8. Sexually Transmitted Infections (STIs) – Basics

<b>Objective</b>	To provide a brief overview of STIs: common STI syndromes/symptoms and types of STIs. The participants have to understand that the same type of STIs which occur in men who have sex with women also occur in men who have same-sex or bi-sexual behavior.
<b>Methods</b>	Slide presentation or overhead projector presentation.
<b>Supplies or Equipment</b>	LCD projector/overhead projector
<b>Time needed</b>	15 min  (Note: This session is to provide a brief overview of STIs to the participants and not to give a detailed training on this topic, which requires a separate training program.)

### Steps

Present the basic information given in the slides and explain where necessary.

### Key points to convey

- Depending upon the site of sexual intercourse, symptoms of STIs can occur at diverse sites - genitalia, anal area, and mouth/oral cavity.
- Any type of STI can occur in persons who have any sexual orientation
- Persons with any sexual orientation may have STIs at any site (genitalia, anal area, and mouth/oral cavity) since their sexual practices may or may not correlate with their sexual orientation.
- Irrespective of whether one identifies as only the insertive or receptive partner (while having sex with other males), the doctor needs to clinically examine and ask for symptoms of STIs in three major sites – genitalia, anal area and mouth/oral cavity.

## 9. STI-Associated Syndromes in MSM and Management

<b>Objective</b>	To introduce the common STI-associated syndromes among MSM, and how to select treatment regimens based on syndromic management approach.
<b>Methods</b>	Slide presentation or overhead projector presentation.
<b>Supplies or Equipment</b>	LCD projector/overhead projector
<b>Time needed</b>	1.5 hour

### Steps

1. Introduce the common STI-associated syndromes among MSM and present the syndromic management approach for each of the major STI syndromes.
2. Flowcharts will help in taking decisions on the clinical management.

**Note:** Treatment guidelines are as per the National Guidelines on Prevention, Control and Management of RTIs and STIs, July 2014. Certain points are adapted from the WHO's 2011 guidelines<sup>4</sup>.

Sexually Transmitted Infections (STIs) in MSM are no different from those that occur in heterosexual men. However, the types of sexual practices determine the site where STIs occur. The major STI syndromes and common causative organisms associated with those syndromes are summarized below.

The World Health Organization (WHO) developed and promoted simplified and syndrome-based approach of management of STIs. This syndromic approach is currently being used in a large number of countries including India. In this approach, diagnosis is based on the identification of consistent groups of symptoms and easily recognized signs (syndromes). The treatment regimen covers the majority of, or the most serious, organisms responsible for producing a syndrome. When a patient comes with complaints, his/her management can be decided according to the clinical management flow chart.

This section discusses the management of the most common STI-associated syndromes. Flowcharts for the management of each syndrome are provided. For all these conditions the sexual partner(s) of patients should also be examined for STIs and promptly treated for the same condition(s) as the index patient.

<sup>4</sup> WHO. (2011). Guidelines: Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people. Recommendations for a public health approach. Geneva: WHO.



STI-associated syndromes among MSM	Possible causative organisms
Urethral discharge	<ul style="list-style-type: none"><li>• <i>Neisseria gonorrhoeae</i>, <i>Chlamydia trachomatis</i> (D to K)</li><li>• <i>Trichomonas vaginalis</i></li><li>• Other organisms like <i>Mycoplasma genitalium</i>, Herpes simplex virus, enteric bacteria and adenovirus</li></ul>
Genital/Anorectal/Oral ulcers	<ul style="list-style-type: none"><li>• <i>Treponema pallidum</i> (Syphilis), <i>Hemophilus ducreyi</i> (Chancroid),</li><li>• <i>Klebsiella granulomatis</i> (Granuloma inguinale),</li><li>• <i>Chlamydia trachomatis</i> L1, L2 and L3 serovars</li><li>• Herpes Simplex Virus (HSV-2 &amp;/or 1) (Anogenital herpes)</li></ul>
Perianal ulcers	Herpes Simplex Virus (HSV-2 &/or 1) (Anogenital herpes), <i>Candida albicans</i> (Perianal candidiasis)
Anorectal discharge	<i>Neisseria gonorrhoea</i> , <i>C. trachomatis</i>
Inguinal bubo	<i>C. trachomatis</i> (L1, L2, L3) (Lymphogranuloma venereum - LGV), <i>Hemophilus ducreyi</i> (Chancroid)
Scrotal swelling	<i>Neisseria gonorrhoeae</i> , <i>C. trachomatis</i>

## Urethral Discharge

- Male patients complaining of urethral discharge and/or dysuria with a history of unprotected sexual encounter in the past 2 months should be examined for evidence of discharge. If none is seen, the urethra should be gently massaged from the ventral part of the penis towards the urethral meatus. (See flowchart 1)
- The major pathogens causing urethral discharge are *Neisseria gonorrhoeae* (*N. gonorrhoeae*) and *Chlamydia trachomatis* (*C. trachomatis*). While gonococcal discharge is usually purulent and non-gonococcal infections usually produce mucoid or watery discharge, distinguishing the type

of infections on the basis of discharge quality is not accurate. In the syndromic management, treatment of a patient with urethral discharge should adequately cover these two organisms. If symptoms/signs persist, assess whether it is due to *Trichomonas* infection and if possible treat with Tab. Secnidazole 2 gm orally. Also assess whether the persistence of symptoms/signs is due to treatment failure or re-infection and refer immediately. .

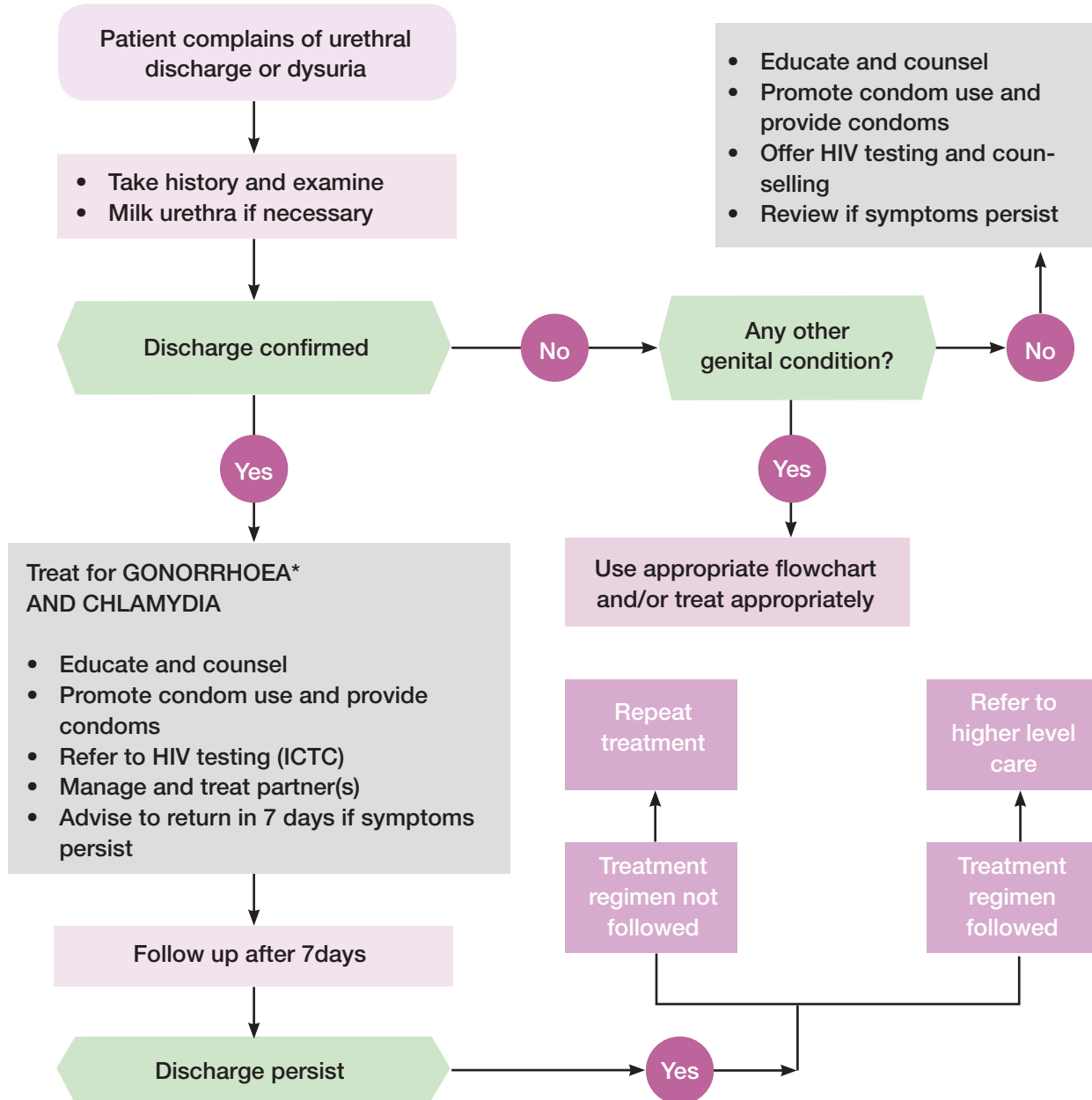
### Recommended syndromic treatment

(NACO Kit 1/Grey)

Tab. Azithromycin 1 gm OD Stat + Tab. Cefixime 400 mg OD Stat



**Flowchart 1: Management Algorithm for Urethral Discharge**



\*If microscopy is available, do Gram stain smear of urethral exudates. If no intracellular gram-negative diplococci are seen, treatment for chlamydial infection only may be considered.



## Genital Ulcer Disease

Patients with genital ulcers should be treated for syphilis (primary chancre), chancroid, and genital herpes. Note that RPR testing needs to be done as a routine in all patients coming for STI screening or treatment. Even if RPR is nonreactive, as per the syndromic approach, treatment for early syphilis has to be given.

A single painless ulcer is more likely to be primary chancre and multiple painful ulcers are more likely to be herpes or chancroid (the former starts as vesicles). However, clinical picture may be altered due to HIV co-infection.

### Note:

- If only vesicles suggestive of genital herpes are present then treatment can be given only for genital herpes.

- Treatment for granuloma inguinale is not included because of its low prevalence in India (but regional differences need to be taken into consideration). If the ulcers are not responding to the standard treatment, HIV infection or the possibility of the ulcers being granuloma inguinale should be considered.

## Recommended syndromic treatment

### If non-herpetic (Kit 3/White):

Inj. Benzathine penicillin (2.4 MU) - 1 vial and  
Tab. Azithromycin (1 gm) - Single dose

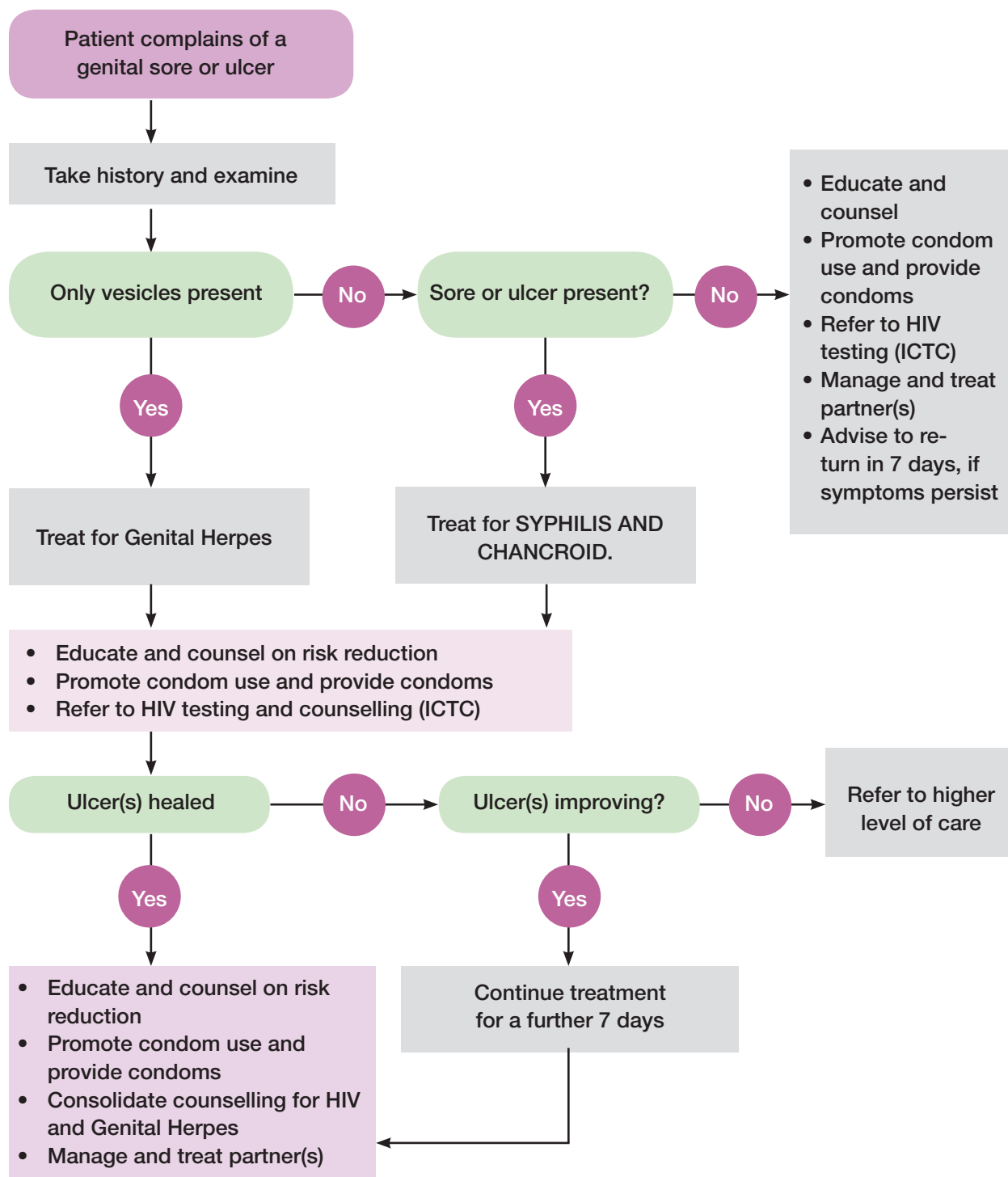
*If allergic to Inj. Penicillin (Kit 4/Blue):*

Doxycycline 100 MG (Bid for 15 days) +  
Azithromycin 1GM (Single dose)

### If herpetic (Kit 5/Red):

Tab. Acyclovir 400 mg TDS for 7 days

**Flowchart 2: Management Algorithm for Genital Ulcer Disease**



<sup>1</sup>Indications for syphilis treatment: VDRL or RPR positive; or patient has not been treated for syphilis recently.



## Anorectal Infections (Anorectal Ulcers and/or Discharge)

Perianal ulcers in a sexually active patient who may or may not give a history of receptive anal sex could be due to perianal herpes, syphilis (primary or secondary) or chancroid. As RPR test sometimes may not be reactive at the time of clinical presentation, treatment of syphilis need to be offered. Anorectal discharge in a sexually active male, who may or may not report having engaged in receptive anal sex, could be due to gonococcal or chlamydial infection.

### Recommended syndromic treatment for anorectal ulcers

*Therapy for perianal ulcers:*

Same regimens as given for the treatment of genital ulcers.

#### If non-herpetic (Kit 3/White):

Inj. Benzathine penicillin (2.4 MU) - 1 vial and  
Tab. Azithromycin (1 gm) - Single dose

*If allergic to Inj. Penicillin (Kit 4/Blue):*

Doxycycline 100 mg (bid for 15 days) +  
Azithromycin 1gm (Single dose)

#### If herpetic (Kit 5/Red):

Tab. Acyclovir 400 mg TDS for 7 days

### Note:

1. WHO recommends addition of treatment for gonorrhoea and chlamydia in MSM with perianal ulcers, even in absence of anorectal discharge. This means in addition to the above regimen for 'non-herpetic' anal ulcers, Tab. Cefixime 400 mg OD Stat needs to be given. Also, in addition to the regimen for 'herpetic' anal ulcers, Tab. Azithromycin 1 gm OD Stat + Tab. Cefixime 400 mg OD Stat need to be provided.
2. Sometimes, *perianal candidiasis may produce fissure and moist lesions mimicking secondary syphilis perianal lesions. If candidiasis is also suspected, then provide Fluconazole 150 mg once daily for 7 days with or without local application of gentian violet or miconazole cream (twice daily) until drying/healing occurs.*

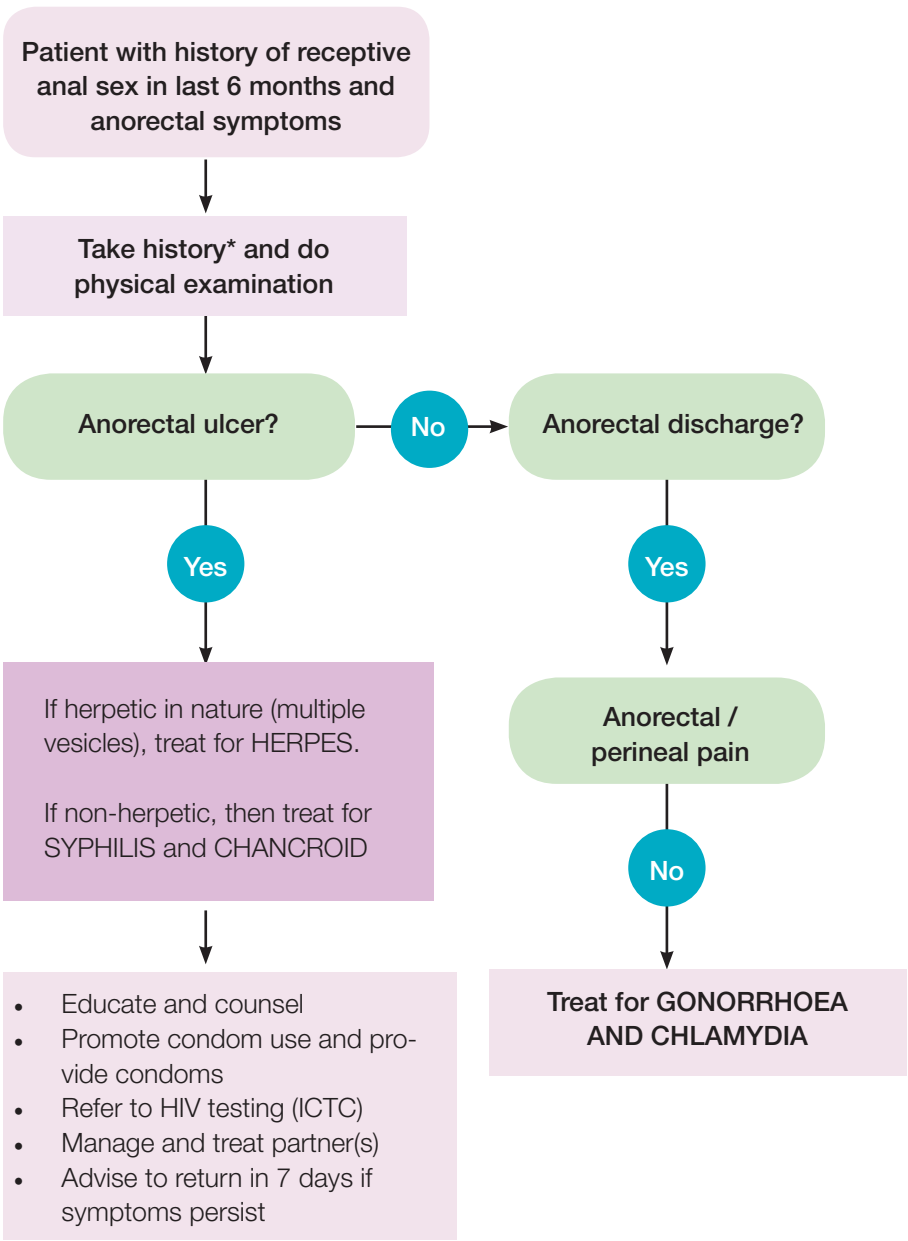
### Recommended syndromic treatment for painless anorectal discharge

Same regimen as given for uncomplicated urethral gonococcal and chlamydial infection:

(Kit 1/Grey)

Tab. Azithromycin 1 gm OD Stat + Tab. Cefixime 400 mg OD Stat

**Flowchart 3:** Management Algorithm for Anorectal infections (Ulcers and Discharge)





## Oropharyngeal Infections (Pharyngitis and/or Ulcers)

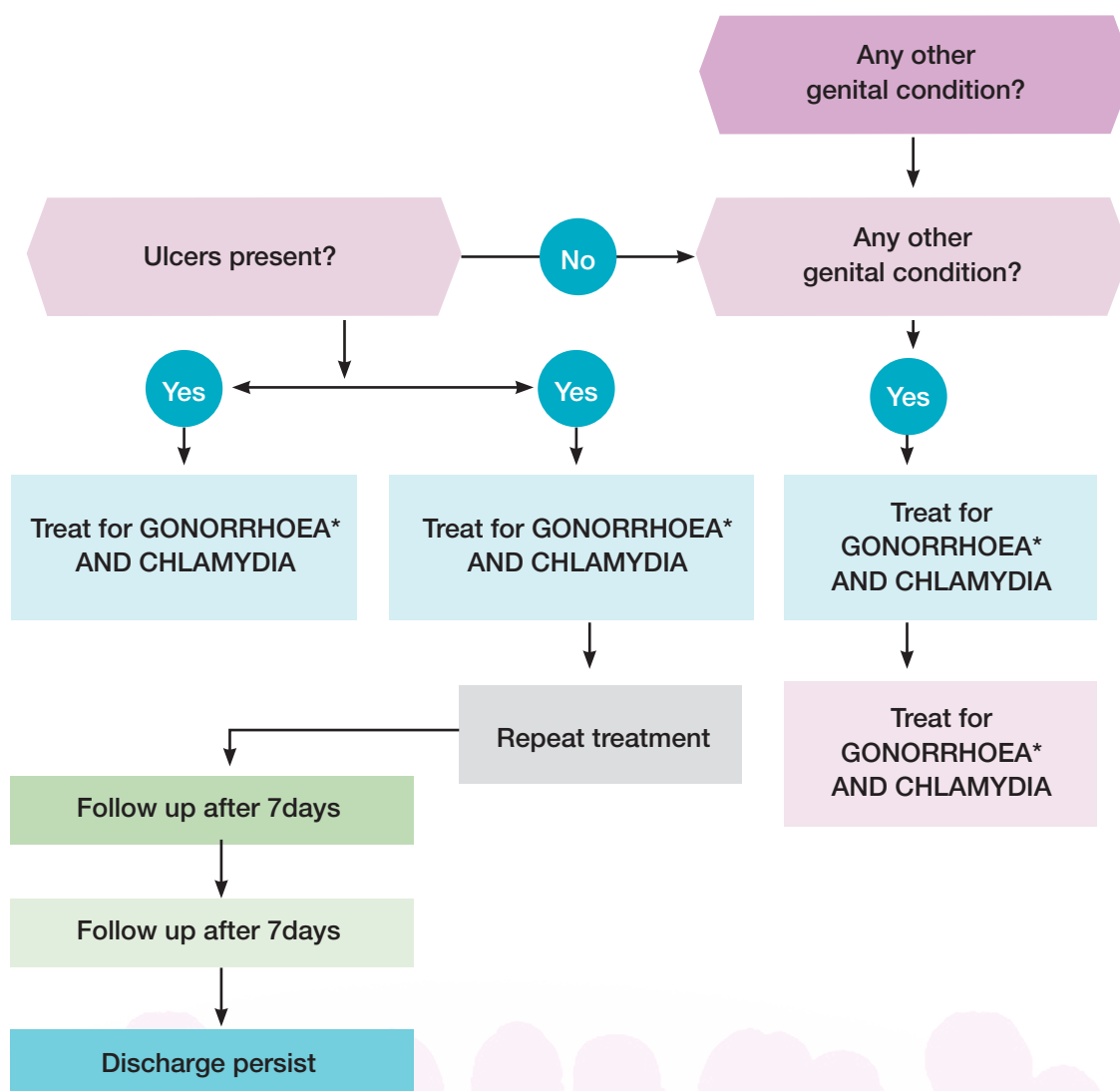
The prevalence of pharyngeal gonococcal and chlamydial infections among MSM in India is not known. Diagnosis of gonorrhea and chlamydial infection in oropharyngeal region is difficult. Pharyngeal gonorrhea can be more difficult to clear than urethral infections. Other oropharyngeal STIs (e.g., herpes and warts) can often be detected by macroscopic examination and managed according to NACO/MoH guidelines.

When a patient presents with symptoms of pharyngitis and a history of unprotected receptive oral sex, then pharyngeal gonococcal and/or chlamydial infection is a likely risk, and he should be treated presumptively as follows:

### Treatment for presumptive pharyngeal gonococcal or chlamydial infection

(Kit 1/Grey) Tab. Azithromycin 1 gm OD Stat +  
Tab. Cefixime 400 mg OD Stat

**Flowchart 4: Management Algorithm for Oropharyngeal infections (Pharyngitis and/or Oral ulcers)**



## Inguinal Bubo

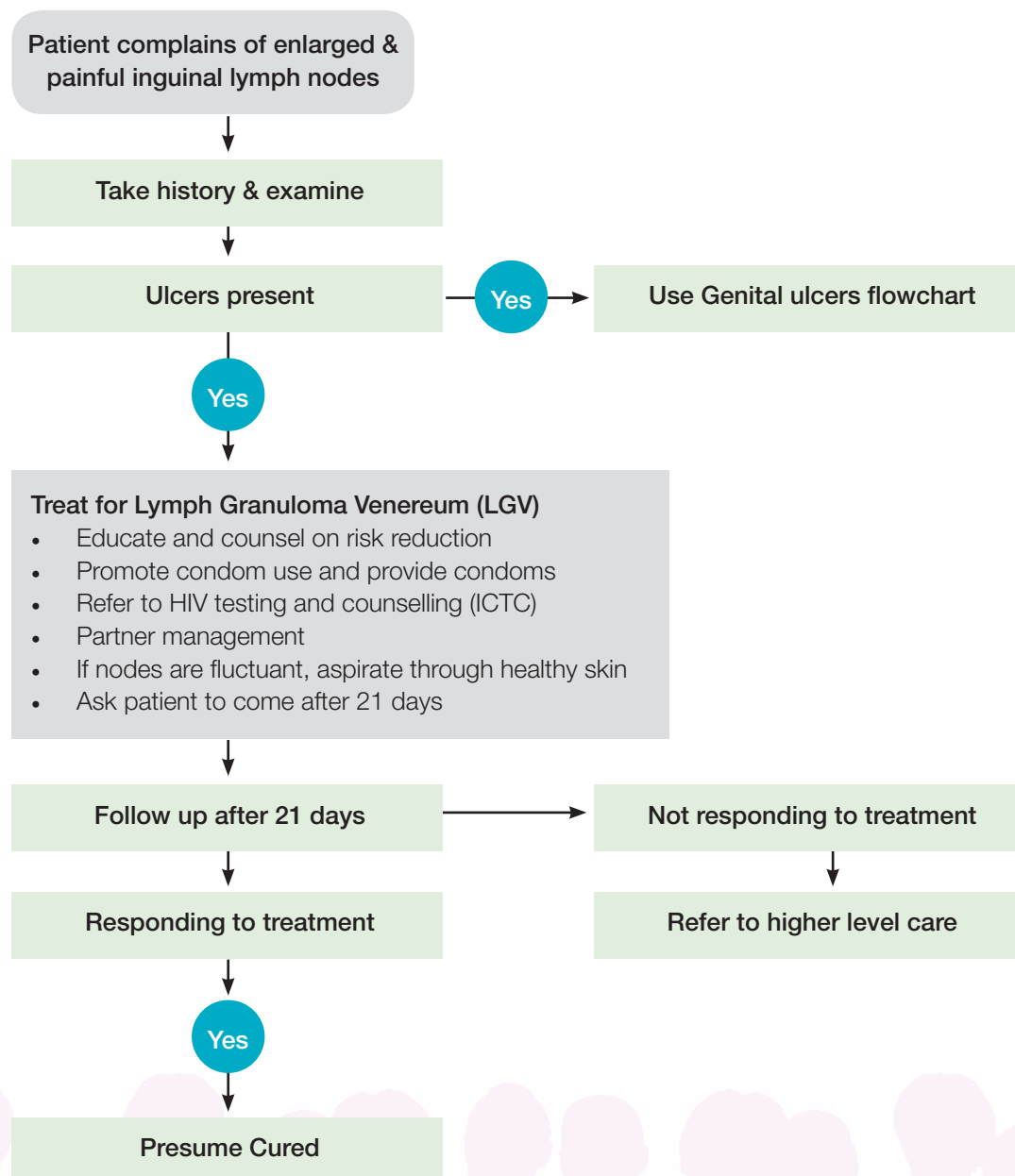
Inguinal and femoral buboes are localized enlargements of the lymph nodes in the groin area, which are painful and may be fluctuant. They are frequently associated with LGV and chancroid. In many cases of chancroid an associated genital ulcer is visible. Non-sexually transmitted local and systemic infections (e.g. infections of the lower

limb or tuberculous lymphadenopathy) can also cause swelling of inguinal lymph nodes. See the flowchart 5 for the management algorithm.

### Recommended treatment<sup>5</sup>

Tab. Azithromycin 1 gm orally once and Tab. Doxycycline 100 mg BD for 21 days Or Tab Erythromycin base 500 mg QID for 21 days.

**Flowchart 5: Management Algorithm for Inguinal Bubo**





## Painful Scrotal Swelling

Inflammation of the epididymis (epididymitis) usually manifests itself by acute onset of unilateral testicular pain and swelling, often with tenderness of the epididymis and vas deferens, and occasionally with erythema and edema of the overlying skin. In men under 35 years this is more frequently caused by sexually transmitted organisms than in those over 35 years. When the epididymitis is accompanied by urethral discharge, it should be presumed to be of sexually transmitted origin, commonly gonococcal and/or chlamydial in nature. The adjacent testis is often also inflamed (orchitis), giving rise to epididymo-orchitis.

It is important to consider other non-infectious causes of scrotal swelling, such as trauma, testicular torsion and tumor. Testicular torsion, which should be suspected when onset of scrotal pain is sudden, is a surgical emergency that needs urgent referral. If not effectively treated, STI-related epididymitis may lead to infertility.

### Recommended syndromic treatment

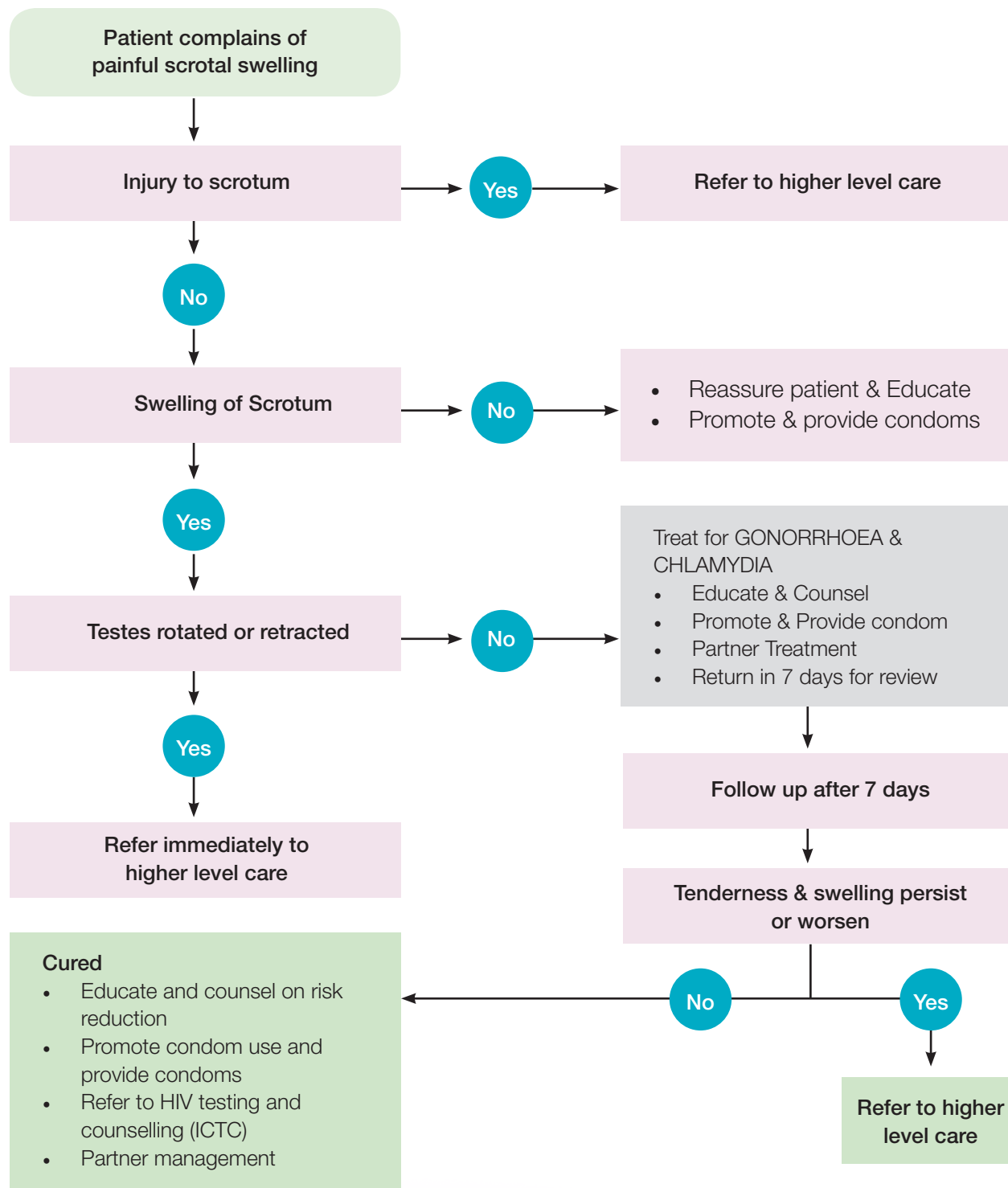
Same regimen as given for uncomplicated urethral gonococcal and chlamydial infection:

(Kit 1/Grey)

Tab. Azithromycin 1 gm OD Stat + Tab. Cefixime 400 mg OD Stat



**Flowchart 6: Management Algorithm for Painful Scrotal Swelling**





## TREATMENT OF SOME SPECIFIC STIS AND ANOGENITAL CONDITIONS

### Genital or Perianal Warts

The human papilloma virus (HPV) is the causative agent for this common STI. Genital warts are painless and do not lead to serious complications. The removal of the lesion does not mean that the infection has been cured. No treatment is completely satisfactory. Podophyllin, podophyllotoxin or trichloroacetic acid (TCA) is used to treat external genital and perianal warts.

#### Treatment

##### Podophyllin or podophyllotoxin

- 20% Podophyllin in compound tincture of benzoin applied to the warts, while carefully protecting the surrounding area with vaseline, to be washed off after 3 hours. It should not be used on extensive areas per session. Treatment should be repeated weekly till the lesions resolve completely. Podophyllin is effective only in moist areas. Podophyllin applied to warts on vaginal or anal epithelial surfaces should be allowed to dry before the speculum or anoscope is removed. Treatment should be repeated at weekly intervals.
- Podophyllotoxin 0.5% solution or gel twice daily for 3 days, followed by 4 days of no treatment; the cycle repeated up to 4 times. Not more than 0.5 ml of Podophyllotoxin should be applied per day.

**Key counselling** messages to all patients diagnosed with HPV infection<sup>6</sup>:

- Genital HPV infection is very common.
- Many types of HPV are passed on through genital contact, most often during vaginal and anal sexual contact. HPV can also be spread by oral sexual contact.
- In most cases, HPV infection clears spontaneously, nevertheless, some infections do progress to genital warts, pre-cancers, and cancers.
- The types of HPV that cause genital warts are different from the types that can cause anogenital cancers. Within an ongoing sexual relationship, both partners are usually infected at the time one person is diagnosed with HPV infection, even though signs of infection might not be apparent.
- Treatments are available for the conditions caused by HPV (e.g. genital warts), but not for the virus itself.
- HPV vaccines are available, which offer protection against the HPV types that cause genital warts.
- Genital warts are not life threatening. If left untreated, genital warts might go away, stay the same, or grow in size or number. Except in very rare and unusual cases, genital warts will not turn into cancer.
- It is difficult to determine how or when a person became infected with HPV; genital warts can be transmitted to others even when no visible signs of warts are present, and even after warts are treated.
- Genital warts commonly recur after treatment, especially in the first 3 months. It is not known how long a person remains contagious after warts are treated.

<sup>6</sup> Based on CDC 2010 STD Treatment Guidelines. <http://www.cdc.gov/std/treatment/2010/genital-warts.htm>

- HPV testing is unnecessary in sexual partners of persons with genital warts.
- If one sex partner has genital warts, both sex partners benefit from getting screened for other STI.
- Persons with genital warts should refrain from sexual activity until the warts are gone or removed.
- Correct and consistent male condom use can lower the chances of giving or getting genital warts, but such use is not fully protective because HPV can infect areas that are not covered by a condom.

## Scabies

The causative mite, *Sarcoptes scabiei*, is transmitted by protracted direct bodily contact. Clothing or bed linen that has possibly been contaminated by the patient in the two days prior to the start of treatment should be washed and dried well, or dry-cleaned.

### Recommended regimen

- Permethrin cream (5%) applied to all areas of the body from the neck down and washed off after 8 - 14 hours.
- Benzyl benzoate 25% lotion, to be applied all over the body, below the neck, after a bath, for two consecutive nights. Patient should bathe in the morning, and have a change of clothing.

### Note:

- Bed linen should be washed/disinfected.
- Sexual partner must also be treated along the same lines at the same time.

## Molluscum Contagiosum

Molluscum lesions are caused by a type of pox virus and usually appear as papules which are smooth, firm and dome-shaped with characteristic central umbilication from which caseous material can be expressed. The removal of the lesion does not mean that the infection has been cured.

### Treatment

- Individual lesions usually regress without treatment in 9 to 12 months.
- Each lesion should be thoroughly opened with a fine needle or scalpel. The contents should be exposed and the inner wall touched with 25% phenol solution or 30% trichloroacetic acid.

## Candidal Balanoposthitis

Balanoposthitis refers to an inflammation involving the glans penis and the foreskin. When caused by *Candida species* it is characteristically found in men with underlying immunosuppressive disease or uncontrolled diabetes mellitus.

### Recommended topical application regimen for balanoposthitis

Clotrimazole 1% cream, twice daily for 7 days  
OR  
Miconazole 2% cream, twice daily for 7 days

### Alternative regimen

Nystatin cream, twice daily for 7 days



## Pubic Lice

The louse, *Phthirus pubis*, is the cause of pubic lice. The infestation is usually transmitted by sexual contact. Patients usually seek medical care because of pruritus.

### Recommended regimen

Permethrin 1%, applied to the infested and adjacent hairy areas and washed off after 10 minutes; re-treatment is indicated after 7 days if lice are found or eggs are observed at the hair-skin junction. Clothing or bed linen that may have been contaminated by the patient in the two days prior to the start of treatment should be washed and dried well, or dry-cleaned.

OR

Lindane<sup>7</sup> 1% lotion or cream, rubbed gently but thoroughly into the infested area and adjacent hairy areas and washed off after 8 hours; as an alternative, lindane 1% shampoo, applied for 4 minutes and then thoroughly washed off.

### *Special considerations*

Infestation of the eyelashes should be treated by the application of an occlusive ophthalmic ointment to the eyelid margins daily for 10 days to smother lice and nits. The ointment should not be applied to the eyes.

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<sup>7</sup> Lindane is not recommended for pregnant or lactating women.

## 10. STI/HIV Testing Recommendations for MSM

<b>Objective</b>	To make the participants to have a brief overview of STI/HIV testing recommendations. The participants have to understand the range of tests that are available and which can be used to diagnose symptomatic and asymptomatic infections.
<b>Methods</b>	Slide presentation or overhead projector presentation.
<b>Supplies or Equipment</b>	LCD projector/overhead projector
<b>Time needed</b>	15 to 30 min

### Steps

*Present the following information and explain where necessary. This information will be given as a handout as well.*

Many STIs do not lead to symptomatic presentations. Thus, regular testing for STIs will identify many infections that would otherwise remain undiagnosed and untreated, although they would be still transmissible in absence of symptoms.

The following recommendations are to encourage regular STI screening of MSM, including those with HIV, who may or may not be symptomatic. The recommendations include STI testing at anatomical sites other than the location of any symptoms that may have led to a clinical consultation.

All men who had sex with men in the previous year should be offered bi-annual screening for HIV<sup>8</sup> and syphilis

Clinical indicators for anal tests (irrespective of the consistency of condom use) include:

- Any anal sex with casual partners
- Any unprotected anal sex
- Any anal symptoms (bleeding, itching, discharge, pain)
- HIV-positive
- Past history of gonorrhea
- Presence of any STIs in other regions (genital or oral)

Lab test for:

- Hepatitis A serology - Immunize if negative
- Hepatitis B serology - Immunize if negative

### Immunization tips for MSM

*HIV-negative MSM:* Once an immunocompetent patient is immunized against HAV and HBV further Hepatitis A or B serology is unnecessary.  
*HIV-positive MSM:* HBV surface antibody levels may be indicated after double dose Hepatitis B vaccination in HIV-positive MSM.

<sup>8</sup> Only after voluntary HIV counselling and informed decision to undergo HIV testing



# 11. Barriers to Health Care among MSM

<b>Objective</b>	To understand the various barriers that prevent MSM from accessing quality health care services and to think of possible solutions to remove those barriers.
<b>Methods</b>	Slide presentation or overhead projector presentation. Discussions
<b>Supplies or Equipment</b>	LCD projector/Overhead projector
<b>Time needed</b>	45 min

## Steps

1. Ask the participants to come up with examples of homophobia in health care. The participants should leave out identifying details (like who said or did what to which persons). In addition to these examples, also discuss the points mentioned in the slides – focusing on health care system barriers. Pick up a few examples for a brief discussion.
2. Discussion
  - a. How these examples or incidents represent barriers to health care for MSM?

- b. What can be done to remove these barriers?

Ask the participants to think how hospitals/clinics can improve the quality of clinical services they provide to MSM. This can be done by dividing them into groups but if there is limited time, then go on to make the presentation on this topic (given in slides). The facilitator is also encouraged to read the full text of the articles mentioned in the slides to have in-depth understanding on the barriers faced by MSM in accessing health services.

## 12. Wrap-Up

### Review training (10 min)

- Review what topics and key concepts have been learned
- Reiterate the key points that they have to be follow in their clinical practice
- Brief them about how as doctors can better equip themselves to serve their clients who are MSM

### Post-training evaluation

Administer the post-training evaluation questionnaire. Ask the participants to write the same number they have written in the pre-training evaluation questionnaire.

### Oral Feedback

You can ask for oral feedback from the participants about the training program and what they have learned in general. This will be followed by giving them feedback forms to fill in.



## APPENDIX 1

# A Model One-Day Training Schedule

<b>Training date</b>	
<b>Organized by</b>	
<b>Training facilitator</b>	
9:30 am	Introduction of the facilitator
9:35	Goal and Objectives of the training
9:45	Ground rules
9:55	Introduction of the participants
10:10	Pre-training evaluation
10:30	Sexuality-related terms (slides and discussion)
<b>11:30 – 11:45 am</b>	<b>Tea break</b>
11:45	Frequently asked questions (FAQs) about homosexuality & MSM
12:15	Sexual Practices (Slides and Discussion)
<b>1 – 2 pm</b>	<b>Lunch</b>
2:00	STI syndromes in MSM and management (Slides and Discussion)
<b>3:15 – 3:30 pm</b>	<b>Tea break</b>
3:30	Addressing same-sex/bi-sexual behavior in STI risk assessment (Discussions and Role-play)
4:15 pm	Barriers to health care for MSM
4:30	Developing action steps to improve quality of services to MSM in doctor's setting
4:45 – 5 pm	Feedback and Post-training evaluation



## APPENDIX 2

# Pre- and Post-Training Evaluation Questionnaire

Note:

- The number and types of questions in the evaluation questionnaire should take into account the topics covered, depth of information conveyed, and the target audience
- For both pre- and post-training evaluation, the same questionnaire will be used)

Participant Number or Name: \_\_\_\_\_

Date: \_\_\_\_\_

Training organized by: \_\_\_\_\_

Training Facilitator: \_\_\_\_\_

Question	Tick (✓)				Official Use
	A	B	C	D	
1. Which one of the following carries <u>highest</u> risk of acquiring or transmitting HIV infection? a. Unprotected anal sex b. Unprotected vaginal sex c. Unprotected oral sex d. Mutual masturbation					
2. Which one of the following will be the <u>best</u> risk-reduction option for a man having anal sex with another man? a. Use condoms only b. Use condoms with water-based lubricants c. Use water-based lubricants alone d. None of the above					
3. Syndromic management of painless anal discharge in MSM a. Azithromycin and Cefixime b. Doxycycline alone c. Erythromycin alone d. Inj. Streptomycin					
4. MSM, if sexually active, need to be vaccinated against which of the following? a. Hepatitis-A only b. Hepatitis-B only c. Both A and B d. Herpes simplex virus (HSV) only					
5. Syndromic management of sexually-acquired oropharyngitis in MSM needs to cover which of the following organisms? a. Gonococci and Chlamydia b. Gonococci, Chlamydia and Herpes c. Gonococci and Herpes d. Chlamydia and Herpes					



Question	Tick (✓)				Official Use
	A	B	C	D	
For the following statements - Say Yes, No or Don't know					
a. Yes					
b. No					
c. Don't know					
6. Anal sex can happen between two men or between a man and a woman					
7. 'Homosexual men' may have sex with women					
8. A (heterosexually) married man can also have sex with other men.					
9. All homosexual men are feminine.					
10. Homosexuality is a psychiatric disorder.					
11. Sexually Transmitted Infections increase the risk of acquiring or transmitting HIV.					

## APPENDIX 3

# A Model Feedback Form

Date:

Venue:

Organized by:

Training facilitator:

**Directions:** Below are a series of paired, opposing statements about various aspects of the course. Please respond to each pair by circling what you would consider the appropriate number from 1 to 5.

1	The course objectives were clearly explained	1	2	3	4	5	The course objectives were not clearly explained
2	The course objectives were consistent with my needs and abilities	1	2	3	4	5	The course objectives were not consistent with my needs and abilities
3	The methods used were appropriate to meet course objectives	1	2	3	4	5	The methods used were inappropriate to meet course objectives
4	The course was well structured.	1	2	3	4	5	The course was poorly structured.
5	The course introduced to me a lot of new knowledge	1	2	3	4	5	The course taught me nothing new
6	The course was appropriate for this group in terms of: a. Content b. Method	1	2	3	4	5	The course was inappropriate for this group in terms of: a. Content b. Method
7	I felt motivated to learn more	1	2	3	4	5	I felt unmotivated to learn more
8	The visual aids were used well and assisted my learning	1	2	3	4	5	The visual aids were used poorly and did not assist my learning
9	The presentation was very easy to follow	1	2	3	4	5	The presentation was very difficult to follow
10	The course handouts were very useful	1	2	3	4	5	The course handouts were not at all useful
11	The tasks/exercises had practical relevance	1	2	3	4	5	The tasks/exercises had no practical relevance
12	The time allocation for the course was perfect	1	2	3	4	5	The time allocation for the course was inappropriate
13	Much of the learning can applied	1	2	3	4	5	I have learned nothing of relevance and practical application



The most useful parts of the course were: (see the agenda for the topics covered). Explain why you feel these topics are most useful.

The least useful parts of the course were: (see the agenda for the topics covered). Explain why you feel these topics are least useful

Do you have any suggestions to improve this course?

Any Other Comments:

*Thank you for completing the form. Your comments are greatly appreciated.*

## APPENDIX 4

# Recommendations for Clinical History Taking from the National Guidelines on Prevention, Control and Management of RTIs and STIs, July 2014<sup>9</sup>

History must be taken in a language, which the client understands well. Clients are often reluctant to talk about their condition due to shyness or fear of stigma. Individuals may come to the clinic with other non-specific complaints or requesting a check-up, assuming that the health care provider will notice anything abnormal that needs treatment. Therefore, health care workers should maintain a high index of suspicion about the possibility of STI/RTI. Hence, health care providers should ensure privacy, confidentiality, be empathetic, understanding, nonjudgmental and culturally sensitive while eliciting history.

Start the conversation by welcoming your client, taking them into confidence and encouraging him/her to talk about their complaints. If a couple comes together, each of them needs to be interviewed and examined separately.

Clients seeking services from ARSH clinics, antenatal care, abortion, infertility and family planning/welfare services should be viewed as opportunities to provide general information about STI/RTI and should be asked about STI/RTI symptoms and referred for services as per the need.

Patients with problems relating to the genital area tend to be guarded and evasive while giving a history.

- Ask an open-ended question, such as “What brought you to clinic?” to initiate a dialogue.
- Phrase your questions in a way such that the opportunity for the patient to mislead you is minimized. For example, “When did you last have sex with someone?” is preferable to “Did you have sex with someone?”

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<sup>9</sup> These broad recommendations on history taking are equally applicable to men who have sex with men.



- Once the subject is broached and patient is comfortable, closed-ended questions (calling for “yes” or “no” answers) can be helpful in eliciting brief answers, for example, “Do you have pain?”
- In order to make an accurate diagnosis it is often necessary to ask more questions during the examination.
- Do not show annoyance if the patient’s history has obvious discrepancies or keeps changing.

### Presenting symptoms and signs

Obtain a detailed history of the presenting symptom/s. Enquire about the presence of other symptoms that are common, such as discharge from the urethra in a patient with genital ulcers, or recurring genital ulcers in a patient presenting with urethral discharge.

### Common Symptoms of STI/RTI

- Dysuria, frequency of urination
- Urethral discharge
- Genital /anal/oral ulceration
- Abnormal growth or mass in genital area / ano-rectal/oro-pharyngeal area
- Acute scrotal swelling, pain
- Inguinal lymphadenopathy
- Genital itching, Balanitis
- Dyspareunia
- Perianal pain
- Anal discharge
- Pharyngitis
- Other illness such as Diabetes mellitus
- Medications - current and Contraception
- Drug allergies
- Past History of catheterization

### Behavioural risk assessment

If the patient is to receive proper education and counselling, these must be preceded by behaviour risk assessment. Make sure that the patient is aware that the history will be kept strictly confidential. Inquire about the following risk factors:

- Marital status: married, living together, single, separated, widowed.
- Occupation: sex workers (male and female), seamen, workers in the hospitality industry, transport workers, migrant workers, etc.
- Unprotected casual sexual encounters (other than with regular partner).
- Previous history of STI.
- History of injections or blood transfusions.
- Substance use: alcohol, drugs (e.g. heroin).
- Tattooing.
- Partner with symptoms suggestive of STI.
- Multiple sexual partners.

### Sexual history

A sexual history must be taken from all patients before examining them and managing their sexual health problems. All individuals should be asked about the following:

- Sex of the partner.
- Type of exposure (oral, vaginal, anal).
- Use of condoms with any type of partner.
- Relationship to partner/s (spouse, regular non-spouse, casual).
- Problems or symptoms in the partner/s.
- Date of last sexual intercourse.
- Number of partners in the past three months.

## APPENDIX 5

# Checklist for Anogenital Examination in MSM

### Penis

- Prepuce: present or not? Retractable? After retraction, look for any lesions over the undersurface of the prepuce, glans penis & coronal sulcus. (Prepuce should be drawn forwards after examination)
- Shaft: Look for lesions (like warts, Ulcers, burrows, rash, etc)
- Discharge: Is it coming from urethra or beneath the prepuce? i.e. Subprepuceal discharge. If no discharge seen but patient complains of discharge, milk the urethra.
- External urethral meatus:
  - Location (Hypo/Epispadiasis), look for inflammation, discharge, stricture, etc.
  - Retract the lips of the meatus to look for intrameatal warts or meatal chancre

(Normal structures or normal variations: Fordyce's spots, coronal papillae, pearly penile papules)

### Scrotal Skin

- Rugosity maintained? (lost in inflammation, and swelling)
- Any redness, swelling, or ulcer
- Lift scrotum to inspect its posterior surface (E.g., Anterior ulceration – Gumma, Posterior Ulceration – TB)
- Look for - Angiokeratoma, Sebaceous cysts

### Testes:

- Size, shape

- Palpation: Any nodularity/irregularity, tenderness
- Compare with opposite testis

### Epididymis

- Size, shape
- Palpate - Globus minor, Globus major & tail

### Spermatic cord:

- Compare thickness with opposite side (Simultaneously palpate on both sides)
- Is it thickened? tender? Varicocele?

### Anorectal Examination:

- Position: Left lateral position with knees drawn up (or in Sim's position) or in knee-elbow position
- Look for inflammation, ulceration, fissure, tags, warts
- Laxity of anal sphincter
- Proctoscopic examination: (Avoid if perianal warts are present) look for pus, inflammation, warts, thread worms.
- PerRectal (PR) Examination - if indicated

### Pubic regions & Groin:

- Groin swelling – Is it hernia or lymphnode enlargement? Description of lymphnodes
- Look for Pediculosis pubis, Tinea cruris, Thrush (candidiasis), Scabetic lesions, etc.



## APPENDIX 6

# Clinical Approach to MSM Presenting with Anorectal Complaints

### **Patient complains of ulcers in the anal region:**

- Looks like anal fissure – Can be primary syphilis (Perform VDRL test)
- Single ulcer, well demarcated painless – more likely to be primary syphilis
- Multiple moist lesions with generalized skin rash (subtle or obvious) – Can be secondary syphilis (Condylomata lata). Perform VDRL test (Rule out prozone phenomenon)
- Multiple small superficial ulcers or coalescent large perianal ulcer(s) – Can be perianal herpes (ask for history of recurrence)

### **Patient complains of anal discharge with or without pain or bleeding**

On inspection - serous or mucopurulent discharge from anus. More likely to be gonococcal and/or chlamydial infection (Proctitis).

### **Patient complains of growth in the anal region:**

Can be warts or any non-neoplastic/neoplastic growths. (Watch for any neoplastic changes in long-standing warts)

### **Patient complains of pain during defecation or bleeding**

No obvious external signs hence need to perform digital and anoscopic examination.

Digital examination:

- Look for piles and internal anal fissure
- Look for discharge on the gloves

Anoscopic examination: (especially if digital examination reveals nothing)

- Look for any ulcers (may be STI-associated – example: Herpes)
- Look for any inflammation (may be STI-associated – example: gonococcal and/or chlamydial infection). Correlate with sexual history. Can take specimens from rectum to rule out gonococcal/chlamydial infection.



## APPENDIX 7

# Physical Examination of Anogenital Region in MSM

### 7-A. Anogenital Examination in MSM: Tips for Making It Comfortable

(This section is adapted from: Clinical guidelines for the management of STIs among priority populations. Australasian College of Sexual Health Physicians.)

Anogenital examination may be embarrassing for some patients and may be a factor in patients delaying presenting to a clinician. Over time, and with practice, clinicians can develop a range of individual techniques to make their patients become more relaxed and comfortable with a physical examination. The following are some tips to provide a good and comfortable examination experience for the patient.

- Good preparation will enable the examination to proceed smoothly and efficiently and won't unnecessarily prolong the examination. Ensure equipment is at hand and ready for use and that the lighting is adequate.
- Explain the examination procedure to the patient and provide an opportunity for questions to be asked prior to proceeding with the examination. Allay any concerns that the patient may have.
- Be understanding of patient sensitivity towards undergoing a physical examination.
- Establish a trusting environment is important to minimise fear and embarrassment. Acknowledging the patient's embarrassment may assist them.
- Often patients need to be assured about the confidential nature of STI testing and diagnosis.
- Ensure the patient is comfortable. Factors that can impact upon patient comfort include an inadequately heated room, lack of privacy, patient uncomfortably positioned and inadequate warming of metal instruments.
- While it is important to avoid unnecessarily prolonging an examination, it is also important to ensure a thorough examination. Developing a systemic approach may help prevent omissions.



## 7-B. Performing Perrectal (PR) Examination in MSM

(Note: Below are the steps for performing a comprehensive anorectal examination. Not all these steps are needed for patients coming for STI check-up)

1. Perform a rectal examination only after explaining to the patient what the examination entails and how it will feel.
2. Drape the patient for the rectal examination so as to avoid unnecessary exposure.
3. Position the patient for the rectal examination in one of the standard positions to allow minimum discomfort to the patient while the examination takes place.
4. Inspect the sacrococcygeal and perianal areas for: masses; inflammation; eruption; excoriations.
5. Palpate any abnormal areas seen on inspection for firmness and tenderness.
6. Inspect the anus for lesions (with the patient straining down).
7. Palpate the rectum (using suitable lubricant) for: anal sphincter tone; tenderness; irregularities; masses; presence and character of stool.
8. Identify changes in anal sphincter that are associated with the aging process.
9. Palpate the prostate and seminal vesicles for: size; shape; consistency; nodules; tenderness.
10. Look at the characteristics of the discharge or fecal material adherent to the examining glove after completing the rectal examination.
11. Test fecal material adherent to the examining glove for occult blood after completing the rectal examination.

12. Record physical examination findings for the anus and rectum.
13. Assist the patient in cleaning up after rectal examination.

## 7-C. Anoscopic or Proctoscopic Examination in A Man

1. Anoscopic examination is best conducted by placing the patient in the lateral Sims position with the patient retracting the right buttock with his right hand and the examiner using his left hand to retract the left buttock.
2. With the patient remaining in the Sims position, the tip of the anoscope should be well covered with a water soluble lubricant, and the instrument firmly but gently pressed into the anal canal while being slowly rotated.
3. It is usually best to pass the scope its full depth before the obturator is removed, and the examination carried out as it is slowly withdrawn.
4. Look for:
  - Discharge (chlamydial or gonococcal infection)
  - Ulcers (syphilis or herpes)
  - Warts\*
  - Lumps or growth
  - Internal hemorrhoids

(\*Avoid proctoscopy or per rectal examination if extensive perianal warts are present since doing proctoscopy may introduce human papilloma virus into the anal cavity)

5. Specimen collection can be done during proctoscopic examination.

